BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF FIFTEEN PATIENTS WITH BRONCHIAL ASTHMA REFERRED TO THE SOCIAL SERVICE DEPARTMENT OF THE PETER BENT BRIGHAM HOSPITAL 1939 - 1945

A Thesis

Submitted by

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(A.B., Boston University College of Liberal Arts, 1944)

In Partial Fulfillment of Requirements for the Degree of Master of Science in Social Service

1946

School of Social Work
Oct. 8, 1946
1259

ACKNOWLEDGMENT

The writer wishes to thank the following persons for their valuable assistance in preparing this thesis: Mrs. Jane Abbott, Director of the Social Service Department, Miss Margaret Jacob, Senior Medical Social Worker, and Dr. Cutting B. Favour, Junior Associate in Medicine, all of the Peter Bent Brigham Hospital; and Dr. Milton Greenblatt, Chief of Services, of the Boston Psychopathic Hospital.

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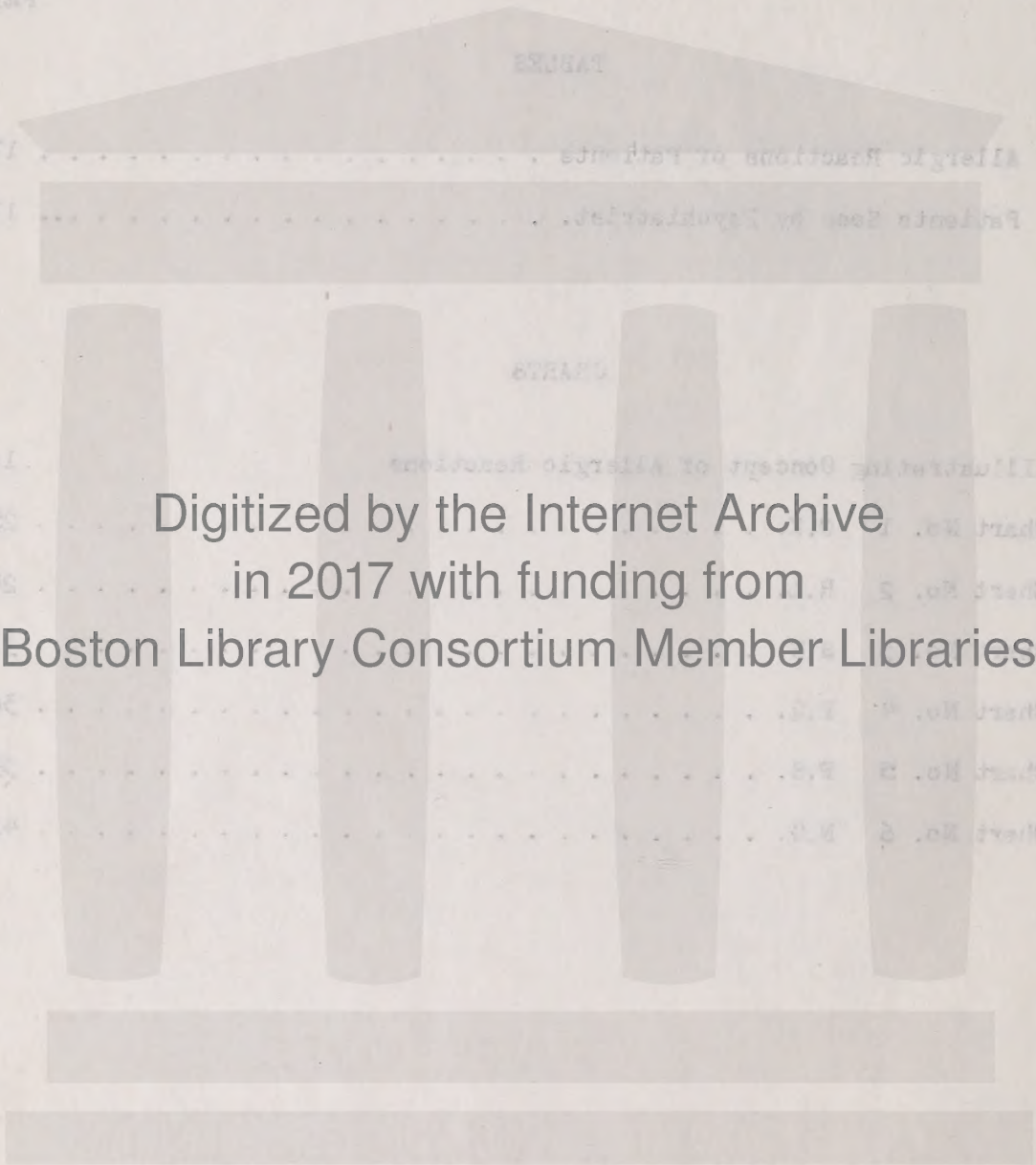

CHAPTER I

INTRODUCTION

Exposition and Purpose

This is a study of a group of patients with a diagnosis of bronchial asthma who were referred to the Social Service Department of the Peter Bent Brigham Hospital by the doctors of the various clinics and wards where they were treated. It was felt by the medical staff that all of these patients had undergone social and emotional experiences which were either the major predisposing factors in their attacks or which markedly aggravated symptoms due primarily to definite allergic sensitivities.

Through a study of the medical, social and psychiatric case records of these patients the writer has endeavored to seek out any demonstrable common factors which may presumably be related to the onset, duration and frequency of symptoms. Special emphasis has been placed on the interfamilial relationships of the patients since it is known that emotional stress in this area is almost always accompanied by malfunctioning of the individual as a whole.

The writer hopes to determine more exactly whether or not there are present:

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(2) Similar specific events or situations which coincided with the onset of the disease.

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subsequent periods of exaccerbation and remission.

While a considerable amount of literature exploring the psychological and physiological mechanisms in asthma has been recorded, the writer failed, in a thorough survey of the field, to find any study which had systematically investigated the social backgrounds of these patients, their family relationships, vocational and economic adjustments. Nor did she find any study which had attempted to make temporal correlations between medical and social data in the hope of clarifying somewhat the relationship between the two. Consequently she became interested in doing this with a small group of patients to see if any general formula could be worked out applying to them which could later be expanded and revised for a larger group.

General assumptions have been made to the effect that asthmatic attacks often follow in the wake of violent emotions; that they are utilized for secondary gain in much the same way that hysterical symptoms are utilized; and that they are related to such conditions as crying, sexual conflict, disturbance of a dependent relationship, and identification with dyspnoeic attacks of others.[1] If a disturbance of a dependent relationship is an etiological factor, in what does it consist? Is it the death of a parent or the jealousy of a sibling; is it over-protection or does it mean that the father's job carries him away from home during vital periods of the child's development? If violent emotion is an etiological factor, by what situations is it provoked? Does it refer to the emotion which arises from witnessing a fatal accident, to that which comes from hating the boss, or is it derived from fear of losing one's only child? Does the presence of

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1 Thomas M. French, Psychosomatic Monograph IV, 1941, pp. 27-34.

sexual conflict mean that the patient is unhappy in marriage, or that he has never married; does it mean that he wants friends among the opposite sex and doesn't know how to make them, or that he has so many as to be considered promiscuous?

If a patient utilizes attacks for secondary gain, is he attempting to provoke the sympathy of his mother, or is he trying to evade mature responsibility? Does crying refer to tears wept over the loss of a loved one, or to tears of self pity? Do attacks occur when the job becomes too difficult, when the mother-in-law comes to visit, or when the husband is committed to a state institution? It is questions such as these that arose in the mind of the writer as she reviewed the literature of psychiatry and medicine and which prompted her to undertake this study in order that she might investigate the specific social events through which the more general theoretical mechanisms of asthma are manifested.

Scope of Study, Sources of Data, and Method of Procedure

The fifteen cases under consideration comprise all patients with bronchial asthma referred to the Social Service Department of the Peter Bent Brigham Hospital between September, 1939 and May, 1945, with the exception of two. These two patients were omitted from the study because they introduced additional factors of extremes in personality and intelligence into an otherwise homogeneous group characterized by essentially average intelligence and neurotic personality disorders. Nineteen thirty-nine was selected as one base year because it marked the introduction into the Social Service Department of a comprehensive system of recording which lent itself more readily to case analysis than did the previous system of recording. Nineteen forty-five was selected as the other base year in order that the

largest possible number of adequately recorded cases in this particular diagnostic group be included in the study. Fifty-one records were examined for this study. Multiple admissions and treatment in different clinics simultaneously and at separate times account for the disparity between the total number of patients and the total number of records. The method of procedure consisted of:

(1) Making a survey of literature in the fields of medicine and psychiatry relating to asthma in order to establish a frame of reference from which to proceed to a social study. (Bibliography appears in Appendix.)

(2) Studying the cases of fifteen individual patients according to a schedule reproduced in the appendix.

(3) Making life charts for six patients for whom there is abundant chronological data. Professor Adolf Meyer, of Johns Hopkins Hospital, originally devised the life chart.[2] It is a method for showing temporal correlation of medical with social data and is a convenient way for illustrating the relationship between the two, i.e. synchronizing social factors with symptoms of illness.

The chart is composed of several parallel vertical columns. The two outside columns are chronological in nature, one showing the year, the other showing the age of the patient during that year. In between them are separate columns for medical data and for social data. The middle column indicates the severity of the disease. When it is filled with a wide black block the patient is suffering from frequent or prolonged attacks; the narrower black block depicts attacks of a more spasmodic, less serious nature; white is used to show periods of relative freedom from attack. Thus, read-

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2 Adolf Meyer, and others, Practical Clinical Psychiatry for Students and Practitioners, p. 10.

ing across one can see at a glance the age of the patient and his medical-social condition at the time. This gives a rough picture of the frequency with which environmental stress occurs at the time of the onset or exacerbations of the disease. In general, events falling into the same year are judged as having a relationship. This method of study is more sociological than psychological in nature and is implemented in this paper by further analysis and interpretation of the case.

Limitations and Values

The major limitation of this study is, of course, the small number of cases included in it. Whatever conclusions are drawn will relate only to this specific group which, although not a selected group from a social case work point of view since it includes all patients referred to the Social Service Department within a given period of time, is selected from a broader medical point of view in that those patients who usually reach the Social Service Department of the Hospital do so because they present particular social or emotional problems. Thus, the more unstable patients of any disease grouping are the ones most likely to be known to the Social Service Department.

Another limitation common to all Master's theses in social service lies in the nature of the records from which data is obtained. These records are not written specifically for the purpose of being used for theses but rather as an aid for the particular agency with whose work they are concerned. In this thesis the author dealt with medical records and psychiatric records, as well as with social records. The medical records were written by physicians primarily for their own use and consequently the emphasis was on the medical. There were variations among the individual

medical records as to the amount of emphasis placed on social and emotional factors, but the overall tendency was for the more recent records to give greater importance and detail to viewing the patient as a whole, a reflection no doubt of the increasing influence of psychosomatic knowledge on the field of general medicine. As the Peter Bent Brigham Hospital is a teaching institution, the medical records were extremely lengthy and full, a factor which was, for the most part, helpful in supplying abundant data. One of the most difficult tasks faced by the author was the weeding out from this mass of data intended primarily for medical usage, factors which would be pertinent to a thesis in social service.

In contrast to the prolific medical records the author found that the psychiatric records and consultation sheets were often of such a concise nature that in many cases little more than a diagnosis could be gleaned. The social service records were for the most part quite full and adequate, although an occasional brief record was encountered where time or the limited service rendered in the case did not permit the obtaining of a full history. However, as the author had three types of records on which to draw, it was possible for her to obtain comprehensive histories on each patient studied by sifting, combining, and correlating information from the various sources and selecting from this material the data relevant to her purpose.

It is believed by the author that this study covers a subject which to her knowledge has not previously been explored from a social case work point of view and which, consequently, may be of use to the medical social worker employed in case work in the following ways:

(1) By establishing a frame of reference which she may use in dealing

with asthmatic patients.

(2) By contributing to a fuller understanding of the asthmatic patient as an individual, particularly in reference to his social background.

(3) By indicating the direction for further study.

The Problem of Asthma

A. Asthma and Allergy

Throughout medical literature from its earliest years, there can be found observations and descriptions of asthma as a clinical entity. It was not until the early years of the present century, however, that it came to be grouped diagnostically under diseases of allergy along with such seemingly unrelated and diverse conditions as hay fever, eczema, uticaria, migraine, serum disease and many others involving the digestive, nervous, and sensory systems of the body.[3]

The word asthma is derived from the Greek term for "panting". References to it can be found in the writings of such ancient authors as Hippocrates, who used it to describe certain types and degrees of breathlessness; Caelius Aurelanius, who gave the first account of an attack; and Galen, who discussed the effects of the humors in the causation of asthma.[4] In the seventeenth century interest in the subject was again revived when Sennertius noted the factor of hereditary predisposition; Van Helmont introduced the concept of nervous or spasmodic asthma, and Willis mentioned many emotional causes which may precede an attack. The first decade of the

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3 Russell L. Cecil, editor, Textbook in Medicine, p. 467.

4 George W. Bray and Arthur F. Hurst, Recent Advances in Allergy, p. 191.

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[2] Russell H. Good, editor. Textbook in Medicine. p. 647.

[3] George W. Bray and Arthur F. Hurst. Recent Advances in Allergy. p. 101.

twentieth century ushered in the beginnings of the present day concept of asthma together with the crystallization of the theory of allergy on which our understanding of the disease is partially based.

Von Pirquet in 1905, as a result of his own observations on serum disease and those of certain of his predecessors, first defined the term. He noted that while an individual who has never been vaccinated with cow pox serum develops, following his first vaccination, a traumatic reaction which takes three or four weeks to resolve, if this same individual is revaccinated at a later date, the second reaction will differ from the first in its accelerated response and rapid resolution. This individual is now allergic to cow pox virus and reacts to it in an altered manner.[5] Accordingly, Von Pirquet coined the term allergy, meaning altered reactivity or altered energy to indicate:

> certain changes of reaction induced by first injections and not related to immunity conferred. Today largely because it is conveniently short and euphonious, allergy has been adopted by common consent to denote the sensitization reactions of man; hence it includes or is synonymous with sensitization, hypersensitiveness, idiosyncracy, anaphylaxis and atopy.[6]

Thus, allergy is a state of exaggerated susceptibility to various foreign substances or physical agents that are harmless to the great majority of people. The allergy may be (a) induced, as in serum disease through passive transfer of sensitized serum, or (b) spontaneous, i.e., acquired or inherited, as in asthma, hay fever, etc.

At about the same time that Von Pirquet was investigating allergy, the relationship of such diseases as hay fever and asthma to plant pollens and

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5 Benjamin Rappaport and Rudolph Hecht, "A Discussion of Asthma from the Point of View of the Allergist," Psychosomatic Medicine Monograph, 1941, pp.1-12.

6 Cecil, op.cit., p. 501.

animal danders began to be considered seriously. Wolfe-Eisner in 1906 demonstrated the specificity of pollens and in 1910 Meltzer introduced the modern concept of asthma by suggesting that the symptoms could be explained on an allergic basis. Asthma is defined today as:

> a dyspnea of a characteristic wheezy type caused by obstruction to the flow of air in and out of the lungs. Such wheezy breathing occurs in a variety of conditions and may be either continuous or paroxysmal; hence the term asthma should be used to indicate not a disease but a symptom. Bronchial asthma is a term which is loosely applied to a syndrome exhibited by patients who between attacks are subjectively and objectively well.[7]

Heredity is important in asthma as studies have revealed a history of asthma or of some other allergy in the families of about forty per cent of all patients. Neurotic traits are also found in higher than average proportions in members of patients' families. Asthma is a fairly common disease, about three and one-half per cent of the population being subjected to it some time in their lives.[8] Diagnosis is made by the history, physical examination, skin tests, and studies of diet and environment. Whatever the initial cause of the asthma, secondary infections of the bronchial membrane frequently develop.

Two basic categories of asthma are generally distinguished:

(1) Extrinsic asthma - including those cases of acquired hypersensitiveness in a susceptible individual to external substances as pollens, danders, dust, drugs, foods, etc. Frequently patients in this group can be helped by discovery and elimination of the offending agent, by the use of hyposensitization methods, or by a combination of both.

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7 Ibid., p. 479.

8 Arthur F. Coca and others, Asthma and Hay Fever in Theory and Practice, p. 171.

(2) Intrinsic asthma - including those cases in which the etiological factors are more obscure since the cause of the trouble lies within the body, is always present, and bears little relationship to changes in residence, season, diet, or occupation. These patients have no demonstrable hypersensitivity. The following are among the factors that predispose to such attacks:

> bacterial sensitization from an obscure respiratory or distant focus or from a preceding infection such as pertussis; endocrine disturbances. . .; physical allergy including . . . heat and cold sensitivity; tissue electrolyte disturbances; and finally, but not of least importance, emotional disturbances.[9]

The patients to be discussed in this paper are divided according to the above mentioned categories.

Concerning psychogenic causes Cecil points out that, "certain patients have histories and courses so bizarre as to preclude any other explanation than a neurosis."[10] On the other hand, it is always necessary to keep in mind the fact that emotional disturbance may be an accompanying feature of the attack, which in itself is a frightening experience, and that the patient may be hypersensitive to some allergen which still remains unknown. Many authors believe, however, that most physicians spend too much time trying to identify this obscure allergen, which is probably of less importance than the emotional component.

The conditioned reflex mechanism or trigger mechanism of emotion has received considerable support from both allergists and psychiatrists alike as an explanation for attacks. According to this theory the original attack of asthma is always a reaction to some allergenic substance, but

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9 Rappaport and Hecht, op.cit., p. 11.

10 Cecil, op.cit., p. 481.

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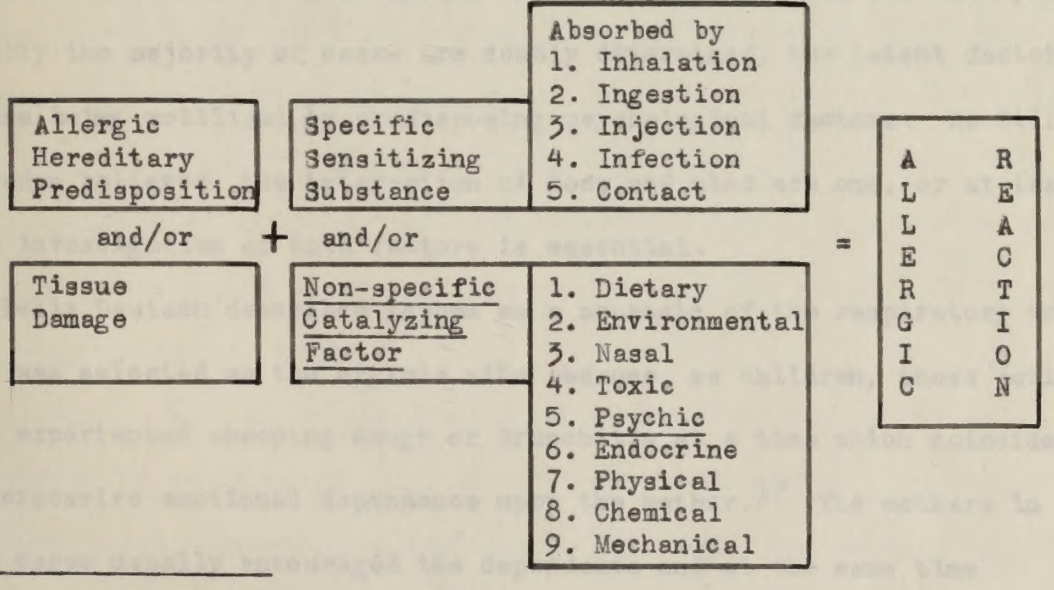
10 Vogel, op.cit., p. 481.

"other stimuli which have been regularly associated with the presence of this substance may also become conditioned to precipitate an attack."[11] Thus MacKenzie as far back as 1886 brought about an attack of asthma in a patient who was sensitive to roses by presenting him with an artificial rose.[12] Other physicians have since repeated this experiment and cited numerous others of a similar nature with identical results. Vaughan refers to an "asthmatic habit which develops in the tissues and which can be set off by factors other than the allergic excitant, such as emotional excitement," etc.[13] Even after the allergic factor has been controlled patients may continue to have attacks due to the stimulation of emotion.

The following chart by George W. Bray graphically summarizes the present concept of asthma.[14]

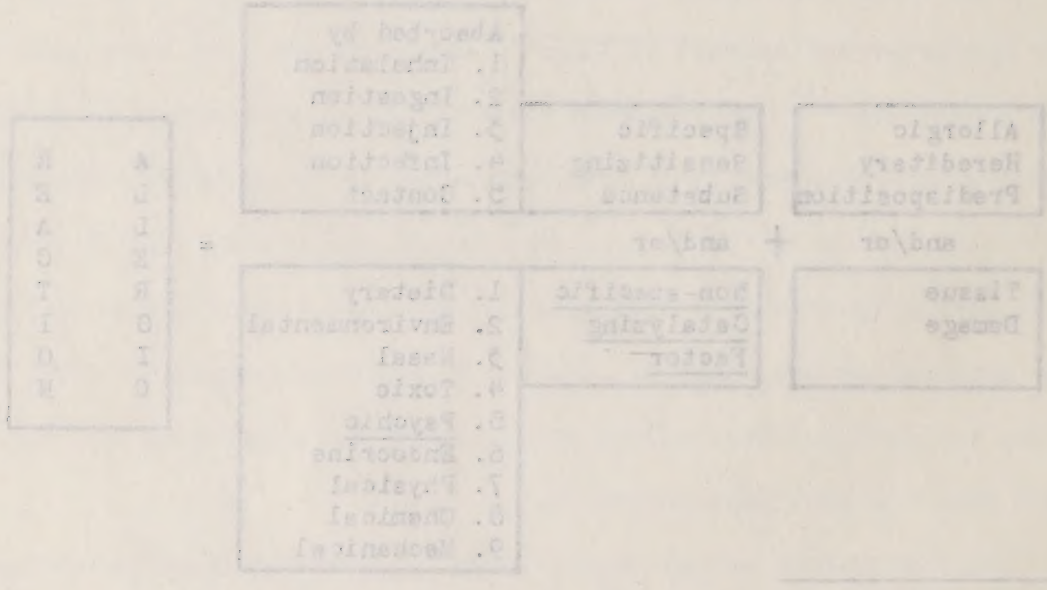


11 Thomas M. French, "Preview of Literature on Psychogenic Factors in Asthma," Psychosomatic Medicine Monograph, 1941, pp. 13-20.

12 J.N.MacKenzie, "The Production of 'Rose Asthma' by an Artificial Rose," American Journal of Medical Science, 1:45, 1886.

13 Richard T. Vaughan, Primer of Allergy, pp. 24 and 61.

14 Bray and Hurst, op.cit., p. 17.



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11 Thomas M. Preston, "Review of Literature on Psychogenic Factors in Asthma," Psychosomatic Medicine Monograph, 1941, pp. 15-20.

12 J.M.Weckerle, "The Production of 'Hose Asthma' by an Artificial Hose," American Journal of Medical Science, 1:40, 1930.

13 Richard T. Vaughan, Primer of Allergy, pp. 37 and 61.

14 Frey and Hurst, op.cit., p. 17.

B. Psychological Considerations

The importance of emotional disturbances in asthmatic patients was noted by careful clinicians long before the principles of allergy were established. Even after their establishment, investigations along psychiatric lines were continued by men who felt that the presence of allergens alone did not, in many cases, explain the attacks. It was known that attacks could be brought on by hypnosis and even by direct suggestion, or by violent affects.[15]

The conclusion most commonly arrived at was that:

> emotional and allergic factors probably stand in a somewhat complementary relationship to each other in the etiology of bronchial asthma. In some cases attacks may be precipitated by allergic factors alone, in others perhaps by emotional factors alone, and in still others cooperation of allergic and emotional factors may be necessary to produce the attacks.[16]

It is difficult to distinguish the specific mechanism for each patient; probably the majority of cases are doubly determined, the latent factors of disease being mobilized by predisposing psychological factors. As Gillespie of London believed, the interaction of body and mind are one, or at least so close investigation of both factors is essential.

Felix Deutsch described Asthma as a neurosis of the respiratory tract, which was selected as the organic site because, as children, these patients often experienced whooping cough or bronchitis at a time which coincided with excessive emotional dependence upon the mother.[17] The mothers in these cases usually encouraged the dependence and at the same time

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15 Harry C. Solomon and J. Yaklovlev, editors, "Psychosomatic Disorders," Manual of Military Neuropsychiatry, pp. 128-157.

16 Thomas M. French, "Summary of Institute Studies Upon Psychogenic Factors in Asthma," Psychosomatic Medicine Monograph, 1941, pp. 35-43.

17 Felix Deutsch, Emotional Factors in Asthma and Other Allergic Conditions, 1941.

suppressed the aggressive tendencies of the children, thus "... a biological and psychological interplay begins forming a combination which lasts throughout life."[18] Deutsch goes on to say that male patients develop a very deep attachment to the mother who is generally a domineering, aggressive, energetic type of woman, soon give up their struggle to achieve independence of her, and develop very passive, sometimes feminine attitudes. If they marry, while they often do not because of their psycho-sexual immaturity, their wives are apt to be similar to their mothers - aggressive, masculine, strong. Girls go through a similar experience of having frequent respiratory infections in childhood, thus fixing the location of the neurosis, but unlike the males, develop personalities frequently characterized by aggressiveness, anger, rage and irritability. They tend to have a more or less conscious hostility towards their mothers, while their relationships towards their fathers is apt to be affectionate, almost seductive. If they marry, their husbands are apt to be effeminate, unsatisfied and unhappy all their lives. Attacks are often initiated in girls when the first sexual interest in the father begins to threaten the little girls with estrangement from the mother.

Dunbar, too, expressed the belief that asthmatics are "somatically prepared" by early respiratory infections more frequently than patients who develop other diseases, and "psychically prepared" by the peculiar emotional coloring which these early illnesses hold for them.[19] A summary of her conclusions concerning the personalities of asthmatics brings out the following characteristics:

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18 Ibid., p. 3.

19 H.Flanders Dunbar, "Psychoanalytic Notes relating to Syndromes of Asthma and Hay Fever," Psychoanalytic Quarterly, 7:25, September, 1938.

1. Disturbances of sexuality involving alienation from the feminine role in the female and feminine identification in the male.

2. Marked predominance of oral and oral sadistic material involving sexualization of the respiratory system and great interest in the sense of smell.

3. Compulsive characters with few protective rituals or phobias except in periods of freedom from somatic symptoms. . .

4. Intense hostility and aggressiveness and a marked tendency to act these out.

5. Weak ego organization with an inadequately assimilated superego which is further projected and externalized. [20]

Always, she stresses, "there is a complex combination of psychic and somatic factors playing different quantitative and qualitative roles in the total makeup of different individuals."[21]

Rogerson and Hardcastle, who have made the major contribution in the study of asthmatic children, state that the child who is in a precarious position in the family--such as the only child, the unwanted child, or the one born soon after marriage before the parents have a chance to form a close relationship between themselves--is the vulnerable one.[22] This appears particularly so if he is born into an unadjusted or difficult family life where the parents tend to compensate for their own marital discord by acting over-affectionate and over-protective towards the child to a pathological degree. The child, in turn, is apt to display a marked lack of self-confidence, and he is a poor mixer, and highly egocentric.

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20 Ibid., pp. 60-62.

21 Ibid., pp. 26-27.

22 C.H.Rogerson, and others, "A Psychological Approach to the Problem of Asthma and the Asthma-Eczema-Prurigo Syndrome," Guy's Hospital Reprint, 85:289, 1935.

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20 Ibid., pp. 60-62.

21 Ibid., pp. 26-27.

22 C.H.Rogerson, and others, "A Psychological Approach to the Problem of Asthma and the Asthma-Eczema-Struma Syndrome," Guy's Hospital Reprint, 25:259, 1935.

Describing the central emotion related to the symptoms, Saul concluded that it is a strong longing for love, basically for the mother's.[23] This longing he believes is similar to the early infantile dependency on the mother. When it is intensified and frustrated or threatened and frustrated, the threshold of allergic sensitivity is lowered and an attack appears. Weiss was originally responsible for the psychoanalytic theory that the wheezing of the asthmatic represents the suppressed cry of the infant as it protests its separation from the mother's body at birth. He suggests that the asthmatic in later life relives the birth experience whenever there is a threat of separation from the parental figure. The asthmatic stands precariously,[24]

> between childhood and adulthood, fearful of giving up his mother, unable to care for himself, unready to assume adult responsibility, yet attempting to seek vicarious satisfaction by giving to others what he himself needs, . . . Consequently he comes into conflict with his own emotional needs . . . Asthmatics become so absorbed in mastering the fear of being left alone that they leave little time or energy to master themselves or the environment.[25]

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23 Leon J. Saul, "Some Observations on the Relationship of Emotion and Allergy," Psychosomatic Medicine, 3:66-72, January, 1941.

24 Edward Weiss, Psychosomatic Medicine, pp. 397-437.

25 Thomas M. French, op.cit., p. 52.

CHAPTER II

PRESENTATION OF CASES

Some Characteristics of the Patients Studied

There were ten females and five males in the study. The ages of the patients at the time of last contact with the hospital ranged from fourteen years to fifty-nine years. Most of them were between twenty and thirty years.

The patients had been known to this hospital for varying lengths of time ranging from one to eleven years, the average being three and one-half years. They had been studied in the Asthma, Medical, Surgical and Psychiatric Clinics of the Out Door Department and on the medical and surgical wards of the hospital. Eleven patients accounted for a total of twenty-seven hospital admissions. The largest number of admissions by any single patient was five, the smallest, one. Five patients had no house admissions and were studied solely in the Out Door Department.

All the males but one had experienced their first attack before puberty, while the females tended to experience their first attacks in the third decade of life. The one male exception to the whole group was free from asthma until the age of fifty-eight. There was a low incidence of first attacks for both sexes in the twenties.

Of the fifteen patients, all were classified as having intrinsic asthma and all patients had attacks which were associated with emotional upsets. Six were considered as having mixtures of intrinsic and extrinsic asthma. The majority were completely negative to all tests and studies for deter-

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mination of specific allergies, as shown in Table I.

TABLE I

ALLERGIC REACTIONS OF PATIENTS

	No. of Patients
Completely negative to all studies	9
Positive to factors in environments	2
Positive to factors in diet and environment	4
Total	15

Slightly more than half the patients were seen by a psychiatrist, the larger number of the interviews occurring while the individual was hospitalized for severe asthma. Due to limited psychiatric facilities in the Out Door Department, it was not possible for all who were seen to be followed there after discharge. The most common psychiatric diagnosis was anxiety neurosis. Some patients were seen by a psychiatrist in the house and also in the Out Door Department.

TABLE II

PATIENTS SEEN BY PSYCHIATRIST

	No. of Patients
Total evaluations	9
Psychiatric consultation in house	5
Psychiatric clinic in Out Door Department or other hospital clinic	7
No evaluation by psychiatrist	6

As children, most of these patients suffered frequently from upper respiratory infections. Colds, whooping cough, bronchitis, pneumonia, diphtheria and influenza were encountered in order of frequency. About half of the patients had at various times manifested other allergic reactions such as eczema, hay fever, and hives, also in order of frequency. Family histories were interesting medically in that one-third of the patients had relatives who had had pneumonia, bronchitis, or tuberculosis, all serious respiratory infections. Over half of the patients had close relatives with either asthma or hay fever.

The backgrounds of the patients showed great diversity in religion and nationality. There were seven Catholic, four Protestant, one Greek Orthodox, and three Jewish patients, an expected distribution in the particular neighborhood in which the hospital is situated. All were white but two, one of whom was a mulatto, the other part American Indian. Although all but three were American born, eleven came from foreign-born parents. It is interesting to note that while ten were members of families with four or more children, all fifteen were either the first, second or third born, these positions being the most precarious ones psychologically. Only one patient went further than high school, seven completed high school, and the others were still attending or had dropped out in the eighth or ninth grades.

Thus, the group as a whole showed no unusual characteristics except, perhaps, ordinal position of birth in the family.

Manner of Presentation

The cases are divided into two groups according to type of asthma. Group A, containing nine cases, is classified as Intrinsic; Group B,

containing six cases, as Intrinsic-Extrinsic.

Life charts precede six of the cases of Group A. Because of the nature of the data in Group B, it was not possible to make any charts for these cases. Following each case is an analysis which includes a summary of the salient factors.

Group A (Intrinsic Asthma)

The patients in this group are all classified as having bronchial asthma, intrinsic type, because it was impossible to find understandable agents outside the body to which they were sensitive and which might be considered responsible for their attacks. All had submitted to numerous skin tests and to studies of diet and environment, and for all consistently negative results had been obtained.

As explained in Chapter II, the term "intrinsic" implies that the essential cause of the trouble lies within the body. According to Rackemann, a general spread of the cases occurs after the age of thirty, which by comparison with the extrinsic-intrinsic group, extends to much older ages.[1] This fact was borne out in the patients studied, since in general the onset of their symptoms began at an older age than did those in Group B. Also, a small percentage of deaths have been attributed directly to intrinsic asthma, whereas none have ever been directly attributed to intrinsic-extrinsic asthma.

CASE #1

The patient, Miss S. L., is a thirty-seven year old single mulatto woman of better than average intelligence. She has worked as a clerk, as an

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1 Francis Rackemann, Clinical Allergy, pp. 373-385.

elevator operator, and as a reporter on a negro newspaper.

Background - Medical, Psychiatric and Social

Miss L. has had bronchial asthma for sixteen years, since the age of seventeen, attacks being associated with colds and emotional disturbances. As a child she had eczema, whooping cough, numerous attacks of tonsillitis, influenza and repeated colds. Several series of skin tests done at this hospital and also at another one have been consistently negative, nor does she show any sensitivity to foods or environment. Her father died at forty-five of tuberculosis, and although she was exposed to his illness, she did not contract it. Her mother died at forty-two of shock. There is no history of allergy in the family. Miss L. has many small sores on her upper back from digging herself with her finger nails during "nervous spells".

While in the hospital Miss L. was seen by the psychiatric consultant, who felt that there was an important emotional factor in the precipitation of her attacks, and she was referred to the psychiatric clinic in the Out Door Department but failed to attend regularly.

Miss L. is the middle child of five siblings born to a refined, educated negress and a musically talented, alcoholic, white German man. She is excitable, nervous, highstrung, emotionally immature, and very dependent. In her early years she witnessed many domestic quarrels because of her father's drinking and inability to make a living. Economic stress was ever present. Orphaned at an early age, she and her older sister went to live with a great aunt described as "queer" and with whom she has never been able to get along. Miss L. has always felt very inferior to her sister, a successful, traveled journalist, who has surpassed her in every way --

attractiveness, popularity and career. She has held many jobs and has done well at them, but has left after a short period of time feeling restless, dissatisfied, and as if she were working beneath her level. Although she left high school after her second year, she is widely read and appears to be well educated. Both her sister and aunt have attempted to choose her friends and run her life. Consequently she feels much hostility towards both, although she has also been dependent on them physically and financially. Miss L. also has strong feelings of being a racial outcast - neither a negro or a white - and while she aspires to be the social equal of the latter group, her appearance marks her distinctly as a member of the former. Socially she feels that she has failed completely because she has never married and she has few friends. Miss L. became very apprehensive during attacks, feared she would die, and demanded constant attention and reassurance.

Precipitating Factors and Analysis

Miss L.'s last attack occurred just after her sister had left the aunt's home to accept a job as society editor of a newspaper in another city and had offered Miss L. her old part-time job on a smaller paper at twelve dollars a week. Miss L. and her aunt, with whom she was now living, had not spoken, except to quarrel, for two months, and although Miss L. expressed the desire to leave home, she felt unable to do it because she feared to live alone. In the hospital her attacks ceased when she was placed alone in a small room and returned when she was allowed to have visitors, or when there was somebody to watch her.

In this case the patient has had asthma since mid-adolescence. The social situation is characterized by constant quarrels at home; loss of both parents while she was still a child; marked jealousy towards a successful

older sister with consequent feelings of inferiority; economic stress; ambivalent feelings of hostility and dependence towards the "queer" aunt who raised her; confusion over racial status; and an inability to find a place satisfactory to herself in the community, either economically, socially or professionally. There has never been a stable, consistent source of love in her life.

CASE #2

The patient, Mr. W., is a fifty-nine year old single male who has worked in the past selling expensive items such as automobiles and typewriters, and more recently as a machinist's helper handing tools to workmen. He left work completely after his recent severe illness, feeling afraid to go back lest he get an attack.

Background - Medical, Psychiatric and Social

Except for bronchitis off and on all his life, Mr. W. was fairly well until two years ago when he suffered from frequent upper respiratory infections. One year ago he had his first asthmatic attack and spent two months in a hospital. He was admitted to this hospital a short time later in an extremely severe attack and for two days remained in status asthmaticus, showing no response to medication. Family history reveals that Mr. W.'s mother had asthma and a sister has hay fever. His father is dead, cause unknown. Mr. W. is negative to skin tests and to studies of diet and environment.

Mr. W. was followed by the psychiatric consultant while in the house, and after his discharge was seen by another psychiatrist on several occasions. A diagnosis of anxiety state was made and it was felt that psychogenic factors were of major importance in his asthma.

Mr. W. was born in Canada, the oldest of three siblings. He is responsive and intelligent, but emotionally immature and markedly lacking in self-confidence. His mother and father separated when he was very young, his father died soon thereafter, and his mother remarried. The foster father did not like him and his mother, to whom he had formerly been quite close, became less affectionate and sent him away to boarding school. Later he fell in love with a girl, followed her from Canada to Boston, but broke off the romance when she told him to "shut up", thereby ceasing, in his estimation, to act like a lady. He could not tolerate such an indiscretion on the part of somebody who supposedly was in love with him. Since then he has lived alone, has had several superficial affairs, but has never married, nor has he formed a deep friendship of any sort. During the depression he suffered a loss of status in his job, and although he was able to remain financially independent, he developed feelings of inadequacy and inability to compete. The only person with whom he feels at ease is a kindly, motherly woman who lives in the same building, keeps an eye on him and gets his meals.

Precipitating Factors and Analysis

Mr. W. experienced his first attack of asthma after receiving from his mother a letter, quite opposite from the usual type, stating that she was disappointed in him and criticizing him in strong language for being a failure. His sister visited him after he had a minor operation and on her leaving he again had an attack. In the hospital he became extremely dependent on the staff, constantly looking for approval and reassurance. When told that he was well enough to be discharged, he developed another attack, thereby prolonging his stay. During his attacks he was very apprehensive

and frightened.

Mr. W. developed severe asthma when he was almost sixty. In his background can be found a history of a broken home in childhood followed soon after by the death of his father and the remarriage of his mother, who henceforth became less loving towards him; sexual maladjustment; an unsatisfactory social life and vocational dissatisfaction mainly from loss of status suffered at work. Particularly striking was his marked desire to be reassured and taken care of by persons who appeared to be strong and capable. Nobody had ever shown him stable or lasting love.

CASE #3

The patient, Charles K., is a twenty-one year old single male, American born. He has been attending business school at night and working in his father's candy store in the day time when his health permits.

Background - Medical, Psychiatric and Social

Charles has had bronchial asthma since age two, progressing in severity and frequency. Within the past four years he has had five admissions to this hospital, twice for lobar pneumonia and asthma, once for bronchial pneumonia and asthma, and twice for asthma alone. His attacks are associated with upper respiratory infections and are aggravated by emotional upsets. Skin tests and studies of diet and environment are negative. As a child he had whooping cough and numerous colds. His father has bronchitis; his grandfather had diabetes and asthma.

No formal psychiatric investigation was made.

Charles was the middle of five children, born to poor Greek immigrants, who were never able to make a satisfactory adjustment to American culture. He is intelligent, ambitious, temperamental, high strung, and considerably

and frightened.

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No formal psychiatric investigation was made.

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LIFE CHART NO. 1 C.K.
(See page 4 for discussion)

Year	Medical Data	Asthma	Social Data	Age
1922				1
	Asthma beings.		Twin brother and sister born; patient goes to live in Greece.	
1924	Whooping cough.			3
1926			Patient develops excessive appetite.	5
	Asthma increasingly severe.			
1928				7
1936	Asthma much worse.		Restricts activities to house and occasional walks. Very concerned over self. Father overprotective.	15
1937	Frequent exaccerbations.		Mother hospitalized with heart disease. Father forces patient to leave school and be tutored at home.	16
1938	Frequent exaccerbations.		Patient in rage runs in front of car. Father diagnosed psychoneurotic. Financial stress.	17
1939	Frequent exaccerbations. Hospitalized.		Sleeping in same room with parents.	18
1940	Improvement physically and mentally.		Patient placed in foster home. Adjusts well; begins to attend school regularly.	19
1941	Continued improvement. Hospitalized.		Returns home. Family cooperates for a while. Works for father in spare time.	20
1942	Hospitalized as emergency. Hospitalized again. Severe exaccerbation.		Unhappy at home. Working hard. Told he must go to dry climate. Afraid to go alone. Mother refuses to let him go. Older sister marries.	21

LIFE CHART NO. 1 C.K.
(See page 4 for discussion)

Year	Medical Data	Asthma	Social Data	Age
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	Asthma beings.		Twin brother and sister born; patient goes to live in Greece.	
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1941	Continued improvement. Hospitalized.		Returns home. Family cooperates for a while. Works for father in spare time.	20
1942	Hospitalized as emergency. Hospitalized again. Severe exacerbation.		Unhappy at home. Working hard. Told he must go to dry climate. Afraid to go alone. Mother refuses to let him go. Older sister marries.	21

preoccupied with his difficulties. Because he was ill so much as a child he was given in to at every step and spoiled by both parents. His father, particularly, stressed his physical weakness and ill health and compared him unfavorably with his siblings. His mother, ill herself with rheumatic heart disease and unable to manage the household and to give the patient individual attention, was possessive and domineering. At the age of seventeen, Charles was still sleeping in the same room with his parents. His closest companion was his older brother, a boy of unusual physical prowess, towards whom he felt very inferior because of his inability to do the same things. When Charles was in the second year of high school his father insisted that he stop going and be tutored at home because of his health. School was a major source of satisfaction and he became so enraged that he dashed into the path of an oncoming automobile. He was uninjured, but his father became even more overprotective. At this time his father was under treatment at another hospital for neurasthenia and his mother was hospitalized with acute rheumatic fever. Financial stress and worry over the family made the father completely ineffective. Charles was experiencing very frequent attacks, and had confined himself to the house except for occasional walks. He was fearful, depressed and apprehensive during attacks. He had few if any friends.

Precipitating Factors and Analysis

At the age of eighteen Charles was placed by his father in a foster home where he remained for almost two years and experienced the best period both physically and emotionally which he had had in the past five years. He returned to high school and attended regularly, got his diploma, was less apathetic and depressed, and lost a great deal of his preoccupation with

himself. A short time after his return home severe attacks appeared again, the first just after the marriage of his oldest sister who had been somewhat of a mother to him when he was a child. He had been working in his father's store, a task which he did not like, and going to school nights. During this time he was also making plans to leave home for the drier climate of the west, but kept postponing his departure because his mother did not want him to go.

In this case a study was made of a young man who had had asthma nearly all of his life. Spoiled and pampered in childhood; in adolescence cut off from his mother's individualized attention because of her own illness and boarded out into a foster home by his neurotic, overprotective father; in his twenties, taken back into his own home to work in his father's store; kept from going west by the possessiveness of his mother, this patient has never known consistent love from either parent.

CASE #4

Mrs. R. L. is a twenty-five year old woman who is separated from her husband. She has a twelve year old daughter.

Background - Medical, Psychiatric and Social

Mrs. L. has had bronchial asthma from the age of twenty-three, with three admissions to this hospital and several emergency admissions to another. Skin tests were negative to fifty antigens and the attacks were unrelated to environment or food. A marked psychic factor was noted. As a child she had had eczema, whooping cough, frequent colds and diphtheria. The family history was negative except for the father who had chronic bronchitis. One brother had died at the age of six from pneumonia.

LIFE CHART NO. 2 R.L.

Year	Medical Data	Asthma	Social Data	Age
1916	Eczema.			1
1920	Frequent colds.			4
1924	Frequent colds.		Gets along poorly with father.	8
1928	Frequent colds.			12
1932	Pregnant.		Illegitimately pregnant by boy of different faith. Marries him before child's birth against wishes of family.	16
1934			Several poor jobs.	18
1935	Miscarriage.		Husband drinks, philanders, irresponsible.	19
1936	Induced abortion.		Difficult life with husband. Many quarrels.	20
1937			Separated from husband.	21
1938			Lives with family. Constant friction.	22
1939	Asthma begins.		Father tells her to leave home.	23
1940	Daily attacks. Symptom free. Hospitalized twice.		Daily quarrels with family. Away from home one month. Returns home - daily quarrels.	24
1941	Hospitalized three times - severely ill.		Attempted reconciliation with husband fails. Quarrels with family continue.	25

Table 3 APT No. 2 A.L.

Year	Medical Data	Remarks	Social Data	Age
1918	Measles.			
1920	Frequent colds.			4
1924	Tonsilectomy.		Cares along nicely with tasker.	8
1928	Frequent colds.			12
1932	Pregnant.		Unfortunately pregnant by boy of different faith. Marries him before child's birth against wishes of family.	16
1934			Several poor jobs.	18
1935	Miscarriage.		Husband drinks, unfaithful. Divorce possible.	19
1936	Induced abortion.		Difficult life with husband. Many quarrels.	20
1937			Separated from husband.	21
1938			Lives with family. Constant friction.	22

No formal psychiatric examination was made.

Mrs. L. was the third of six children in an excitable, foreign born Jewish family of marginal income. She is easily discouraged, anxious, emotional, with great lability of mood. She got along poorly with her father from childhood and received little affection from her mother. When she was in the first year of high school she became illegitimately pregnant by an Irish-Catholic boy whom she married just before the birth of the baby. The displeasure of her entire family was incurred at this time and the difficulties with her father became more pronounced because of the pregnancy and marriage to a man of different religion. She lived with her husband for several years and then left him because of his drinking and irresponsible nature, to return home with her child. However, her feelings toward him remained ambivalent. At one time when she was considering returning to him, she learned that he had made another unmarried girl pregnant. Living at home was extremely difficult for she knew that she was not wanted, yet she had no other place to go. She did not return to high school and had no special vocation. Her father never forgave her; there was constant quarreling which involved the whole family; and financial stress increased the tension. On several occasions her father threatened to throw her out of the home. Mrs. L. exhibited some affection for her child but felt that she did not know her as well as her parents did, because she was sick too often to take care of her. Actually the child was a source of annoyance to her. During her hospitalizations she was very frightened and discouraged.

Precipitating Factors and Analysis

The first attack Mrs. L. had occurred after a family quarrel. Once her asthma began, she had attacks almost every day; there were quarrels

almost every day. The only time the patient was symptom free was during a one month period when she left her family and child to take a job as waitress in another town. It was noted that visits from her family were followed by attacks. On two occasions she had attacks when told that she was to be discharged from the hospital.

The patient in this case is a young woman who has had severe asthma for two years. Her family life, always hectic, is characterized by marked hostility on the part of her father, lack of affection from her mother, and constant quarreling among all members of the group. Marriage was unsuccessful because of her husband's alcoholism and instability. Economic stress and vocational unpreparedness were also factors. This patient has never known an unwavering love from either her parents or from her husband.

CASE #5

The patient, Miss S. N., is a twenty-three year old single woman who has worked as a clerk and as a Civil Service stenographer.

Background - Medical, Psychiatric and Social

Miss N.'s asthma began five years ago and was moderately severe until the past year and a half when it became very severe. It was thought to be on an infectious basis as she also has pansinusitis, but it was also noticed that attacks could be brought on by emotion and that emotion made them much worse. Attacks always occurred at home; never at work. She had a history of hives, whooping cough, and diphtheria. One sister had had asthma but was now symptom free.

No formal psychiatric examination was made.

Miss N. is the oldest of five siblings. As a child she was considered

LIFE CHART NO. 5 S.N.

Year	Medical Data	Asthma	Social Data	Age
	Hives, Whooping cough.		Gets along poorly with father. Bites nails. Very close to older brother.	Childhood
1938	Diphtheria.			16
1939	Asthma begins.		Last year high school. Wants to be a nun. Father objects, gets along poorly with him.	17
1940	Mild exaccerbation.			18
1941	Mild exaccerbation.			19
1942	Symptom free.		Away from home on civil service job. Disillusioned in "low" morals of girls. Only friends are nuns, whom she visits often.	20
1943	Several colds.		Father urges her to return home, sends money. Returns home. Father overprotective.	21
1944	Severe exaccerbations. Hospitalized. Exaccerbations.		Only boy she has ever been interested in marries somebody else suddenly - unhappy. Returns to work feeling it is too soon. At work, woman says she has tuberculosis. Doesn't get along with girls in office. Fears may lose job for too much sick leave, though doesn't like working there.	22
1945	Progressively worse. Hospitalized. 1/22. Improved. 2/12. Exaccerbation. 2/17. Daily attacks of asthma begin. 3/7. Medical emergency. 4/5. Improvement.		Hasn't heard from older brother for one month. Dr. advises southwest. Says wants to go but says mother won't let her. Letter from brother, implying he is badly injured. Told she can go to work. On way home meets aunt with letter from brother implying he will never walk again. Very worried re him and re self. Afraid of dying. Worried. Afraid to go to southwest alone for fear of attacks, no one to care for her. Afraid doctor will be angry. Feels helpless. Brother recovers.	23

very nervous and bit her nails. She is a serious, retiring, religious-minded, straight-laced person who is extremely apprehensive about herself and very much concerned with the details of medications and treatment. There is much underlying friction in the family between the parents who come from different economic and cultural backgrounds. Her mother's family was fairly well to do, socially prominent, and highly educated; her father's, of marginal income and poorly educated. Miss N. seems fond of her mother, who is domineering, abrupt and very set in her ways. Her father is a passive but talkative individual who until recently showed very little interest in her. Now he calls her his favorite child, comes to the hospital with her for clinic visits and is extremely overprotective towards her. She is suspicious of his real love for her, and her feelings towards him are very ambivalent. She has always been very close to her older brother who is now in the Navy, playing with him when they were young and going out with him when they were older. She has never been out on dates and the only boy in whom she was ever really interested, a boy with whom she was only casually acquainted, married unexpectedly, leaving her very disappointed. She has never "trusted" girls because she feels their morals are very low and that they like to gossip. She graduated from high school and did well on her job as a clerk but did not like it because she could not get along with the girls in her office. However, she was very much attached to her boss, a protective fatherly man. Young people make her uncomfortable; older ones put her at ease. There has never been any marked economic stress since she and her father have always made a living. In the hospital she got along well and responded to treatment. During attacks she became panicky, afraid of dying, and often called for her father.

Precipitating Factors and Analysis

Miss N.'s first attack occurred when she was a senior in high school. At this time she wanted very much to be a nun, but her father refused to allow her to enter a convent because he stated that he did not want to lose her. Her longest period of freedom from attacks was when she worked in Washington, for sixteen months. This was the only time she was ever away from home. Here her sole friends were the nuns of a nearby convent. At her father's insistence she returned home when she became ill with a cold. She developed asthmatic attacks again and has continued to have them with increasing frequency and severity. When told that she was to be discharged from the hospital she had an attack; when she learned that her brother was wounded she had an attack; when told that she was well enough to work, she had another attack; when plans were being made for her to go west she seemed enthusiastic but developed a series of bad attacks, finally expressed her fear of going alone, and improved when plans were cancelled.

The patient in this case developed asthma in midadolescence. Suspicious of the sincerity of the emotion which prompted her father's show of overconcern; dominated by an undemonstrative, unhappy mother; aware of constant friction between her parents; left by the only person in whose love she had ever felt secure - her brother; lacking friends of either sex; this patient manifested a strong desire to leave home, yet fell back on her asthma as the reason for not doing so.

CASE #6

Mrs. N. B. is a forty-three year old American born married housewife with three children.

Background - Medical, Psychiatric and Social

Mrs. B. had her first attack of asthma at the age of thirty-nine. As a child she had had bronchitis many times and pneumonia twice. All tests at this and at another hospital where she was previously studied have been consistently negative. Since the onset of her asthma she has visited many private doctors, tried every known medication, and led a bed-chair existence, but with no relief of symptoms. It was felt that there was an important emotional element.

Mrs. B. was followed by the psychiatrist in the Out Door Department at regular though progressively less frequent intervals for a period of four years.

Mrs. B. is irritable, restless, somewhat depressed, and anxious, a woman who becomes upset at the slightest provocation. She stated that her childhood was very unhappy because she had to do all the housework and was not permitted to go out and enjoy life. Her parents were overprotective and strict and undemonstrative. Although brought up in the Jewish religion, she married a Protestant man and is now attending the Christian Science Church. Her marital life is not fully satisfactory as there are financial worries and occasional religious differences. She was reluctant to reveal much about it. It was felt much friction did exist. Her husband is a very "good man", devoted and intelligent, but is becoming discouraged because of her disability. She laments the fact that she has caused him so much trouble having him take care of her and give her her medicines and injections. Mrs. B. worries a great deal about her son who is in the Navy and about her inability to send her daughter to college. Her other daughter, who is married and living with her since her husband is also in the Navy,

Background - Medical, Psychiatric and Social

has a baby who upsets Mrs. B. considerably by her presence. She feels imposed upon by this daughter. During attacks she becomes terrified of dying. In between attacks she talks in a whisper for fear that she will cough and start an attack.

Precipitating Factors and Analysis

Mrs. B.'s first attack followed the sudden death of a boarder who lived in her house. Although she failed to respond at home to the medication of her family doctor, she responded to a small amount of exactly the same medication in this hospital. It was noted that in the neutral environment of the hospital the patient did a great deal of dry coughing without precipitating an attack, whereas the same thing at home brought one on very quickly. When told that she was to be discharged another attack occurred, as it had under similar circumstances in the hospital where she had previously been a patient. Patient also had attacks whenever her son who was in the Navy, and on whom she was very dependent, left home after having been there on leave.

This patient whose asthma developed in her late thirties has a background of feeling involved and imposed upon in childhood, religious conflicts in her married life, financial stress and worry about the future of her children, and annoyance with her grandchild. It was noted that she complained about being a burden to her husband yet derived considerable satisfaction from attention given her by him and by members of the hospital staff, as if attempting to compensate for the lack of attention which she felt as a child.

Year	Medical Data	Asthma	Social Data	Age
1906				1
1919			Comes to America with brother alone.	13
1923	Illegitimate daughter born.		Father of child disappears as she decides to marry him.	17
1924			Second love affair. Man leaves her to return to Italy. Employer reprimands her.	18
1925	Miscarriage.		Dismissed from job as maid for petty thievery. Threatened with deportation as undesirable alien.	19
1926			Marries but does not tell husband about child.	20
1929	Son born.			24
1930			Applies for permanent placement of illegitimate child.	25
1935			Illegitimate daughter legally adopted.	31
1937			Mother dies of asthma.	32
1939			Husband treated for peptic ulcer. Family on relief.	34
1941			Patient's illegitimate daughter, unmarried, becomes pregnant, has miscarriage.	36
1942	Asthma begins. Hospitalized.	■	Illegitimate daughter reappears. Husband still does not know of her. Security threatened.	37

LIFE CHART NO. 4 P.Q.

Year	Medical Data	Asthma	Social Data	Age
1906				1
1919			Comes to America with brother alone.	13
1923	Illegitimate daughter born.		Father of child disappears as she decides to marry him.	17
1924			Second love affair. Man leaves her to return to Italy. Employer reprimands her.	18
1925	Miscarriage.		Dismissed from job as maid for petty thievery. Threatened with deportation as undesirable alien.	19
1926			Marries but does not tell husband about child.	20
1929	Son born.			24
1930			Applies for permanent placement of illegitimate child.	25
1935			Illegitimate daughter legally adopted.	31
1937			Mother dies of asthma.	32
1939			Husband treated for peptic ulcer. Family on relief.	34
1941			Patient's illegitimate daughter, unmarried, becomes pregnant, has miscarriage.	36
1942	Asthma begins. Hospitalized.		Illegitimate daughter reappears. Husband still does not know of her. Security threatened.	37

CASE #7

The patient, Mrs. P. Q., is a thirty-seven year old foreign born housewife, mother of three children.

Background - Medical, Psychiatric and Social

Mrs. Q. developed severe bronchial asthma suddenly two months ago. She had been essentially well until that time. All studies in this hospital were negative. Her mother had died of asthma five years ago.

Mrs. Q. was seen by psychiatric consultant who made a diagnosis of anxiety neurosis and stated that patient's attacks were a refuge from a difficult family situation and were used to help make her the center of sympathetic attention.

Mrs. Q. was born in Italy, the oldest of a large family of low economic level. She has always been anxious, nervous and fiery tempered. At the age of twelve she left school to help out financially since her family was living on a marginal income. At the age of sixteen she came to America by herself and obtained a job in a factory. She did not feel at home in this new country but desired to remain here since her family could not care for her. She became illegitimately pregnant within a short time. Although she did not want to marry the man at first, she later changed her mind, but found that he had disappeared. She felt abandoned and lost. She did not want the child who was boarded out, and later legally adopted by somebody else. She then obtained a job as a domestic. Her employer, who knew of the child, discovered that she was having an affair with another man and threatened to discharge her. Mrs. Q. wanted to marry this man but he suddenly left her and went back to Italy. Mrs. Q. was later discharged after it was found that she had stolen several small articles. Her employer also

CASE #7

The patient, Mrs. P. Q., is a thirty-seven year old foreign born housewife, mother of three children.

Background - Medical, Psychiatric and Social

Mrs. Q. developed severe bronchial asthma suddenly two months ago. She had been essentially well until that time. All studies in this hospital were negative. Her mother had died of asthma five years ago.

Mrs. Q. was seen by psychiatric consultant who made a diagnosis of anxiety neurosis and stated that patient's attacks were a refuge from a difficult family situation and were used to help make her the center of sympathetic attention.

Mrs. Q. was born in Italy, the oldest of a large family of low economic level. She has always been anxious, nervous and fiery tempered. At the age of twelve she left school to help out financially since her family was living on a marginal income. At the age of sixteen she came to America by herself and obtained a job in a factory. She did not feel at home in this new country but desired to remain there since her family could not care for her. She became illegitimately pregnant within a short time. Although she did not want to marry the man at first, she later changed her mind, but found that he had disappeared. She felt abandoned and lost. She did not want the child who was boarded out, and later legally adopted by somebody else. She then obtained a job as a domestic. Her employer, who knew of the child, discovered that she was having an affair with another man and threatened to discharge her. Mrs. Q. wanted to marry this man but he suddenly left her and went back to Italy. Mrs. Q. was later discharged after it was found that she had stolen several small articles. Her employer also

attempted to have her deported as an undesirable alien but was unsuccessful. Again she felt mistreated and alone.

At the age of twenty Mrs. Q. married but did not tell her husband of her illegitimate child. Subsequently she had three children by him and was fairly happy although the children irritated her and made her nervous. Her husband was a meek, passive man who often stayed home to take care of the children while she went out.

In the hospital patient was extremely upset and did not want to return home when she was ready to be discharged.

Precipitating Factors and Analysis

Mrs. Q.'s first attack occurred just after her illegitimate daughter appeared at her home, curious to know what her mother was like. Mrs. Q. became panic stricken for fear that her husband would discover the existence of this girl, who had also been illegitimately pregnant, but had miscarried. It was noted that attacks occurred in the hospital when patient was refused special privileges and attention; when her husband left her after visiting her; when two cousins who knew of her daughter's existence came to see her; and when the daughter herself came into the hospital.

In this case the patient's background revealed an early separation from the protection of her family, a trip alone to a strange country, attempts to gain love through successive affairs with several men, all of whom deserted her, lack of security in work, and even in her right to remain in this country. When patient was in her late thirties, the reappearance of her illegitimate daughter threatened her marriage which had been shakily built on the ignorance of her husband about the existence of this daughter, and coincided with her first asthmatic attack.

LIFE CHART NO. 5 P.S.

Year	Medical Data	Asthma	Social Data	Age
1928				1
1932			Stepsister in reform school.	4
1936	Asthma begins.		Economic stress - both parents drinking a lot.	8
1940	Attacks at home; no attacks at school.		Doing fairly well in school.	12
1941	Moderately severe attacks.		Mother in hospital after father beats her.	13
1942	Severe exaccerbations.		Doing poorly in school. "My mother hates me." Father planning to place boy in foster home, break up home and divorce mother. Both parents drinking heavily.	14

LIFE CHART NO. 3 P.S.

Year	Medical Data	Asthma	Social Data	Age
1928				1
1932			Stepsister in reform school.	4
1936	Asthma begins.		Economic stress - both parents drinking a lot.	8
1940	Attacks at home; no attacks at school.		Doing fairly well in school.	12
1941	Moderately severe attacks.		Mother in hospital after latter beats her.	13
1942	Severe exacerbations.		Doing poorly in school. "My mother hates me." Father planning to place boy in foster home, break up home and divorce mother. Both parents drinking heavily.	14

CASE #8

The patient, Paul S., is a fourteen year old American born school boy of average intelligence.

Background - Medical, Psychiatric and Social

Paul was well until six years ago when he developed asthma which has since become progressively worse. For the past two months he has been having attacks every night. All tests of diet and environment were negative. It was believed that patient's asthma was largely on an emotional basis resulting from an intolerable home situation.

No formal psychiatric examination was made.

Paul was the only child of foreign born elderly parents, both of whom drink. He is reticent and shy, though apparently eager to be liked and recognized. His father is his mother's second husband, she having been divorced by her first husband. Three children of her first marriage are in and out of the home. All are of low-grade intelligence and one was in a mental institution for a time with a diagnosis of schizophrenia. Paul's father and mother quarrel all the time. The father, a well-meaning but rather inadequate individual, seems fond of the boy but blames the mother for his illness. She is questionably psychotic, drinks excessively, is having a difficult menopausal period, and is completely inconsistent in her attitude towards Paul. One month she is good to him, the next she turns on him. Paul believes that she hates him yet he seems anxious for her approval. Mother recently was in a hospital covered with bruises which she claimed were given her by the father. Father claimed they were self-inflicted and that she was out of her mind. When father shows affection for the boy,

CASE #2

The patient, Paul S., is a fourteen year old American born school boy of average intelligence.

Background - Medical, Psychiatric and Social

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No formal psychiatric examination was made.

Paul was the only child of foreign born elderly parents, both of whom drink. He is reticent and shy, though apparently eager to be liked and recognized. His father is his mother's second husband, she having been divorced by her first husband. Three children of her first marriage are in and out of the home. All are of low-grade intelligence and one was in a mental institution for a time with a diagnosis of schizophrenia. Paul's father and mother quarrel all the time. The father, a well-meaning but rather inadequate individual, seems fond of the boy but blames the mother for his illness. She is questionably psychotic, drinks excessively, is having a difficult menopausal period, and is completely inconsistent in her attitude towards Paul. One month she is good to him, the next she turns on him. Paul believes that she hates him yet he seems anxious for her approval. Mother recently was in a hospital covered with bruises which she claimed were given her by the father. Father claimed they were self-inflicted and that she was out of her mind. When father shows affection for the boy,

mother becomes jealous and fights with them both. The father has rarely made a living due to his alcoholism and financial stress is ever present.

Precipitating Factors and Analysis

Paul's present series of attacks followed the father's decision to break up the home and have the boy placed in a foster home with the idea of taking him back to live with him when and if he is able. Attacks always occurred at home, never in school where patient is happy and does fairly well.

This patient, who has had asthma since childhood, has quarrelsome, elderly parents, both of whom are alcoholic; apparent concern by inadequate though well meaning father, who now has plans to board patient out; and extreme inconsistency in attitude of mother, interpreted by patient to mean hatred for him. The mother seems jealous of attention which the father gives to the patient.

CASE #9

The patient, Mrs. N. G., is a forty-five year old married foreign born woman with twin sons thirteen years of age.

Background - Medical, Psychiatric and Social

Mrs. G. has had hay fever for fourteen years and asthma for ten years with attacks progressively becoming worse and more frequent. During the past seven years she had eight admissions to the hospital for her asthmatic condition. All scratch and patch and food tests were negative, nor was there any correlation of attacks with upper respiratory infections. Family history is negative for allergies. It was felt that social and emotional difficulties played an important part in the patient's illness.

LIFE CHART NO. 6 N.G.

Year	Medical Data	Asthma	Social Data	Age
1899				1
1914			Strict pious upbringing. Strongly attached to father who did not drink or smoke.	15
1928			Married.	30
1929	Hay fever begins.		Pregnant.	31
1930			Twin sons born.	32
1933	Asthma begins.		Repeal - husband begins to drink, frightens and disgusts her by appearance.	35
1934	Mild attacks.			36
1935	Mild attacks.			37
1936	Medical emergency. Hospitalized, severe attack.		Works hard caring for home and children, little time for relaxation, worried about self.	38
1937	Relatively free of asthma attacks.			39
1938	Relatively free of asthma attacks.			40
1939	Relatively free of asthma attacks.			41
1941	Severe exaccerbations. Hospitalized three times.		Worried over husband's increased drinking and neglect of self and sons. Many quarrels. Depressed.	43
1942	Hospitalized two times. Frequent exaccerbations.		Family friction increases. Husband's drinking increases. Priest advises separation.	44
1943	Hospitalized, severe exaccerbation. 3/10. Exaccerbation. 2/22. Better.		Blames husband for attacks. Seen by psychiatrist and told she must make choice - ambivalent. Priest talks to patient and extracts promise from husband to reform. Patient reassured. Rapid progress. Both psychiatrist and priest skeptical.	45

LIFE CHART NO. 6 H.S.

Year	Medical Data	Asthma	Social Data	Age
1899				1
1914			Strict pious upbringing. Strongly attached to father who did not drink or smoke.	15
1929			Married.	30
1929	Hay fever begins.		Pregnant.	31
1930			Twin sons born.	32
1933	Asthma begins.		Moved - husband begins to drink. Frightens and disgusts her by appearance.	35
1934	Mild attacks.			36
1935	Mild attacks.			37
1936	Medical emergency. Hospitalized, severe attack.		Terrible bereaving for home and children, little time for relaxation, worried about self.	38
1937	Relatively free of asthma attacks.			39
1938	Relatively free of asthma attacks.			40

Mrs. G. was followed by the psychiatrist while on the ward. He stated that little success could be expected from psychotherapy as patient was an extremely immature person whose infantile reactions were deeply rooted.

Mrs. G., the middle of five children, is nervous, high strung, irritable, depressed and immature, a person who worries considerably about her illness and her family troubles. She was brought up in a strict, pious Catholic family and her father, to whom she was extremely attached, did not drink or smoke. Her husband on the other hand came from a family that always drank to a moderate extent, enjoyed life and had many friends. She could not accept the fact that he came from a different background from her, liked to drink and go to parties, and devoted her married life to trying to reform him and to make him over in the pattern of her father. There were constant quarrels about his drinking and staying out nights. Ambivalence characterized her attitude towards him; for although she complained bitterly over his behavior and his neglect of her and the children, she refused to leave him even on the advice of the priest. With her husband she was extremely possessive, unreasonable, irritable, would not let him have any friends, and did not have any of her own. She stated that she was fond of her twin sons but overprotected and spoiled them and was apparently annoyed by them. Financial stress has never been an important part of the picture.

Precipitating Factors and Analysis

Mrs. G.'s asthma began shortly after the repeal of prohibition when her husband began to drink excessively. He arrived home one night in an intoxicated condition, threw himself across the bed and wakened her from sleep to make sexual advance towards her. Mrs. G. became frightened,

disgusted and had her first attack of asthma. Since that time she has frequently had attacks when her husband comes home drunk, when he doesn't come home at all, or when she worries over his lack of attention towards her. Several times when attacks have begun she has taken her twin sons to her sister's home and there the wheezing has stopped completely. She has never had an attack at her sister's home though her attacks occur very frequently and she visits her sister frequently. In the hospital it was noted that she did better when left alone and that she made a constant bid for sympathy, freely airing her marital difficulties and assuming a martyr-like attitude of the good wife who had suffered. When told by the psychiatrist that she would have to decide about staying with her husband, she had an attack. She made rapid progress after the priest had extracted a promise from the husband to the effect that he would change. The priest was skeptical himself that this would happen. On several occasions she failed to respond to treatment by her local medical doctor at home but responded quickly to exactly the same treatment in the neutral atmosphere of the hospital.

A study of this patient brings to light the following points of significance - overattachment to her father in childhood and presumably overattention on his part; disappointment in marriage because her alcoholic husband did not fill her father's role of giving constant attention and demonstration of love; an unsatisfactory social life outside of home; and annoyance with her children.

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CHAPTER III

PRESENTATION OF CASES (Continued)

Group B (Intrinsic-Extrinsic Asthma)

The patients in this group are all classified as having an intrinsic-extrinsic type of asthma since it was possible to demonstrate their hypersensitivity to certain factors outside the body, but at the same time the presence of these allergic reactions alone did not adequately explain the frequency and severity of their attacks. As explained in Chapter II, this group develops symptoms from a double causation, partially within themselves, partially outside of themselves, and the interrelationship of the two is so close that it is difficult, if not impossible, to tell where one begins and the other ceases. Patients in this grouping frequently first develop asthma in childhood and rarely acquire it after the age of forty-five.[1] The present study bears out this fact, as all but one developed their symptoms in childhood and the one exception fell well into the forty-five year limit, her first attack occurring at thirty.

CASE #10

Dolores is a fifteen year old American born girl who is in her third year at high school. She is of high average intelligence.

Background - Medical, Psychiatric and Social

Dolores has had asthma since the age of two and one-half and has been in numerous hospitals since that time. She has a positive reaction to so

1 Francis Rackemann, op.cit., pp. 373-385.

many kinds of allergens that desensitization has been discarded as futile. A tremendous emotional element was noted and it was felt that psychiatric treatment was the most suitable form of therapy. As a child she had eczema and frequent colds. Family history was negative for allergies.

Dolores showed marked improvement under a regime of treatment instituted by the psychiatrist. She has been followed by him in the Out Door Department for one and one-half years.

Dolores lives with three maiden aunts and a widowed grandmother. She is shy, reticent, intelligent and very anxious for approval and recognition. Her father, an erratic, talented Italian artist, committed suicide at the age of twenty-five. Her mother, an American Indian, is thought to be psychotic, although she has never been committed. She is in and out of the home and has given birth to five illegitimate children since Dolores was born. There has been much gossip in the neighborhood about this, and Dolores often hesitates to play with certain of the children for fear that they will tease her. She has little to do with her mother, although she sees her when her mother decides to live with the family. The aunts set extremely high standards for her and object to her friends, whom they think are not good enough for her. The aunts are of Indian descent while Dolores' friends are all Italian. Dolores would like to study at art school, but her aunts have kept her from doing this; consequently she does not enjoy school and is not doing as well as her intelligence would indicate she can do. Economic stress has never been a major factor since all the aunts work and contribute to the family income.

Precipitating Factors and Analysis

Dolores, with a history of asthma dating almost from infancy, has had

a difficult childhood in that her parents were both extremely unstable. To this was added the factor of diversity in race and culture. The father's suicide at an early age and the mother's questionable mental status threw responsibility for her upbringing upon a group of four quarreling, domineering female relatives, none of whom has shown an understanding of her need for love. That Dolores' aunts discourage any identification with her father can be seen by their defiance of her desire to follow in the pattern of his artistic career and by their opposition to her choice of friends among young people of his race.

Constant conflicting loyalties, desire to break away from her relatives and a fear of the consequences for doing so, dissatisfaction with school and the vocational choice made for her, and fear of neighborhood gossip mark her present social situation. There has never been a satisfactory relationship with either father or mother, or father or mother surrogate.

CASE #11

The patient, George E., is a twenty-two year old American born male of foreign parentage. Although of high average intelligence, he has never been able to hold a job for any length of time.

Background - Medical, Psychiatric and Social

George has had asthma since the age of nine and has been followed in this hospital for twelve years. He had frequent bouts of bronchitis beginning at the age of five. Family history is negative for allergies. George also complains of severe headaches thought to be on an emotional basis. He was referred from the medical clinic to the psychiatric clinic after many

medications had been tried unsuccessfully, and it was felt that the attacks were due to a large psychic element superimposed on an allergic background.

A diagnosis of neuraesthenia was made. The psychiatrist in the Out Door Department felt that his personality symptoms were ominous and that psychotherapy would be of little help. It was believed that he was utilizing his pulmonary pathology for evasion of mature adult responsibilities and that he was preoccupied with sexual problems. He was discharged from this hospital and transferred to another one because it was felt he could not be helped here.

Little was learned about George's home and family as he was evasive and uncommunicative about these matters. He is almost always in a state of tension and apprehensiveness concerning himself. He made a constant bid for sympathy, and sought people out often to describe to them his multiple aches and pains, though he had no real friends. After finishing high school he did nothing for a while, held one or two temporary jobs, and finally enrolled in a mechanical course at a trade school. He began to drink while there in order to help him get through. Although he claimed that he was worried about finding suitable employment, he used his symptoms of asthma and headaches to keep from working. It was noted that the two symptoms were rarely present together; that when he used one he was able to drop the other. Both symptoms were brought on by emotion and excitement. He felt inferior to other people and complained because he thought his clothes were not as nice as theirs. He also worried about financial difficulties and not having enough spending money.

Precipitating Factors and Analysis

In this case is found a patient who has had asthma for the major part

of his life. An inadequate family history was obtained. This patient was the most severe psychoneurotic of the group, and his prognosis both psychiatrically and medically was very poor, since he capitalized on his asthma to maintain his immaturity, and was embarking on a pattern of alcoholism.

Definite vocational and social maladjustments were present with marked feelings of inadequacy regarding economic status and appearance.

CASE #12

The patient, Selma F., is a seventeen-year-old girl, American-born of foreign parentage, who is in her last year of high school.

Background - Medical, Psychiatric and Social

Selma has been known to hospitals ever since early childhood. Born with bilateral congenital clubfoot, she has had several operations which have completely corrected the right foot and have made the left one serviceable, although not normal. She has had hay fever since the age of four and at eleven developed asthma, for which she has been treated at this hospital for a number of years. She was a sickly baby, and had many colds and minor accidents. Her mother has asthma and her father, hay fever. It was believed that the large degree of tension in the home contributed to her attacks.

Selma was under treatment at a Child Guidance Clinic for six years between the ages of nine and fifteen. She had been referred for stubbornness, disobedience and other antisocial behavior. Both parents were described as ineffectual and incompetent and it was thought that the unstable family life as well as the patient's physical deformity were responsible for her behavior.

Selma is the third of four children in a family of marginal economic level. She is a moody, willful adolescent of low normal intelligence who is considerably "spoiled". As a child she was pitied and indulged because of her frequent illnesses. Her family discouraged her and told her she could not do many things because she was so weak. Her mother is an extremely emotional, domineering woman who has been diagnosed as a psychoneurotic and is so preoccupied with her own troubles that she has been unable to give any thought or energy to Selma's training. She is very overprotective towards her, yet lacks patience and understanding. She fights with her constantly, verbally and physically. The mother has often told Selma that nobody will ever bother with her after she (the mother) dies. Selma is very dependent on her mother, yet has a great deal of hostility towards her, which she expresses quite openly.

Selma's father is an emotional, unhappy man with a flaring temper. He has never been able to make an adequate living and constantly berates his wife for her poor financial management.

Selma has never gotten along well with other children, for she always wants to be the boss. There is a great deal of sibling rivalry and she feels very inferior to the healthy members of the family, who tease her and quarrel with her. She has done poorly in school because of frequent absences.

Precipitating Factors and Analysis

There is constant friction in the home and the patient has fairly frequent attacks. However, when she stays at her married sister's home, which is quiet and orderly, she never has an attack.

The patient in this case had a noticeable physical deformity to complicate her situation. A study of her background revealed two neurotic parents, incapable of deflecting enough of their love away from themselves towards the patient to make her feel really wanted; parents impulsive yet overprotective, indulgent yet domineering. Numerous family quarrels, economic stress, sibling rivalry and poor social adjustment outside of the home were also noted.

CASE #13

The patient, John T., is an anxious, apprehensive twenty-two-year-old American-born male of average intelligence. At present he is unemployed.

Background - Medical, Psychiatric and Social

John has had asthma since the age of eleven, and from that time he has had numerous colds associated with asthmatic attacks. Conflicting results were found on patch, scratch and food tests as patient was negative to all except two foods which could be easily eliminated, but claimed to have been found allergic to "almost everything" at another hospital at another date. It was presumed that he did have definite allergies, however. John's asthma was worse in the summer and fall. One sister died of pneumonia. His father developed asthma at the age of forty-two, one year before John developed his. It was felt that there was a large psychic element in John's attacks.

A diagnosis of anxiety state was made and although a psychiatric consultation was requested while John was on the ward, it was not obtained.

John is the younger of two sons born to immigrant parents of low economic level. He is very apprehensive about his physical condition. Both

parents are extremely overprotective and have inculcated in John the feeling that he is a very weak, inferior person physically. John's brother, three years his senior, is strong and healthy and successful in his job as an accountant. John admires him yet is quite jealous. The father is a very emotional, somewhat feminine man who cries easily and blames himself for being so concerned about John that he could not let him go to another state and climate a year ago when he was offered a job there. The father has not worked for four years because of his own asthma, and prior to that time held many jobs but had no definite trade. John's mother is the strong person in the family, having worked as a maid to help out financially. She is extremely possessive towards John, treats him very much like a child, bundling him up in heavy sweaters and scarf and continually admonishing him about his poor health. John has held many odd jobs since he left high school at the age of fifteen, but has never kept any one for longer than six months. He is constantly dissatisfied yet unwilling to learn a definite trade. He has few if any friends.

Precipitating Factors and Analysis

John had an attack a few hours after he arrived home after being discharged. Although he had been having frequent attacks for years, it was noted that he was always completely symptom-free when staying with a particular aunt.

In this case the patient has developed asthma in childhood, one year after his father developed it. His records reveal a history of overprotection with domination on the part of emotional foreign parents, rivalry with an older, stronger sibling, and economic stress. Identification with the father who has attacks is probably also a factor. It is apparent that he

is also following his father's pattern of drifting from job to job and is all too ready to be taken care of by his strong, masculine mother.

CASE #14

The patient, Mrs. R. K., is a tired looking, frail thirty-two year old American-born married housewife. She has six small children and looks much older than she really is.

Background - Medical, Psychiatric and Social

Mrs. K. developed hay fever and asthma two years ago and has attended clinic regularly since that time. She is allergic to ragweed but it was felt that other problems in the home aggravate this condition. She has had occasional eczema. There is no family history of asthma.

No formal psychiatric examination was made.

Mrs. K. has always been closer to her older sister than to her mother. Her sister is an aggressive, domineering and quick-tempered person. Without her help, Mrs. K. would have been unable to maintain her house and care for her children. Her husband has been in a mental hospital twice, with a diagnosis of dementia praecox, paranoid type. He has also been arrested several times for drinking. When he is at home he appears fond of patient but is often cranky, gruff, irresponsible, and difficult to get along with. Mrs. K. married him after knowing him for only two months, and appears to care for him very much. Their marriage occurred just after she had graduated from high school and had worked only a short time. After marriage the children came quickly and the family income was often limited and irregular. Towards her sister Mrs. K. has very ambivalent feeling, for she blames her for antagonizing her husband to the point where he had another breakdown,

and at the same time admits that she could not get along without her. At the time of Mr. K.'s breakdown, Mrs. K. was in a nursing home and her sister was living in her home, cooking and taking care of the children, whom she ruled with an iron hand. Mrs. K.'s sister blames Mr. K. for her difficulties, stating that she was a happy, normal girl before her marriage, but has never been the same since. Mrs. K. has no close friends because she states there is no time to spend with them.

Precipitating Factors and Analysis

Patient had first attack of asthma while her husband was in a state hospital. The family was living on an inadequate income and she was very worn from caring for her six youngsters. She improved when he was released but became worse when he began to show symptoms again. During this period she remained very stolid, resented her sister but said nothing, and showed little outward emotion. Although she had been having numerous attacks in her own home which was surrounded by ragweed, she was sent to a nursing home which was surrounded also by ragweed. She was not informed of this fact and while there she was completely free from attacks. Soon after her return home her husband was again committed to a state hospital. Patient broke down and wept, vented her aggression towards her bossy sister, and withstood this crisis without an attack.

This case described a patient with a domineering older sister who acted as a mother surrogate, and towards whom the patient felt markedly hostile yet very dependent. Her own parents had always played a minor role in her life, and support from them was not forthcoming when she needed it. From her husband she knew some love, but this was often colored and inconsistent due to his alcoholism and to his periods of psychosis when he was taken away

from her to be hospitalized. The burden of six little children and financial insecurity added to her difficulties.

CASE #15

The patient, Mrs. L. S., is a twenty-two year old American-born married woman with one child, aged eight months.

Background - Medical, Psychiatric and Social

Mrs. S. has had intractable bronchial asthma at all times for the past five years with hay fever in the spring and in the fall. Skin tests show that she is mildly sensitive to timothy and ragweed. One sister also has hay fever and asthma. It was felt that this woman's symptoms were aggravated by an unsatisfactory social situation.

No formal psychiatric examination was made.

Mrs. S. is the second of four children, one of whom is married, the other two at home with her parents. She is attractive, of average intelligence, and quite concerned with talking about her difficulties. Her father is a chronic alcoholic and has been drinking for as long as she can remember. Her mother had a difficult time rearing and caring for the children, and although concerned with their well being, urged Mrs. S. to leave home as soon as she was able to work because of the constant tension at home, and the financial difficulties. Mrs. S. came to Boston alone at the age of sixteen and worked first as a domestic and then in a factory until her marriage at twenty-one. She did not enjoy working or living alone and was very happy to be married.

Mrs. S.'s husband is an Armenian man ten years her senior, a member of the Greek Catholic Church. As she is Protestant and of a native American

family, their cultural backgrounds are different. She feels that he is the only person who has really been kind to her and on whom she can depend. Consequently when he was drafted, this was a great blow to her. She felt that she was no better off than before her marriage. When she became pregnant she went to live with her mother-in-law, a capable, domineering woman who is very foreign in manners and customs. She is afraid that her mother-in-law will attempt to raise her daughter in the old world manner and in the Greek Orthodox religion. There are constant quarrels between the two women. Her brother-in-law, who also lives in the home, pays very little attention to her, but spends a great deal of time with the baby. She feels hurt because he ignores her. Although she expresses affection for the baby, there is evidence that she resents the child for tying her down. Outside of the home, she has few if any friends.

Precipitating Factors and Analysis

The patient's first attack of asthma occurred when she found herself alone in Boston. Although patient resents her mother-in-law and the fact that she is so dependent on her, she continues to remain with her because she is afraid to be by herself during an attack, and cannot return to the home of her own parents because she feels she will be in the way. Her attacks have so increased in frequency while living in this emotionally charged atmosphere that she cannot work at all, a fact which does not seem to disturb her.

This case described a young adult woman who developed asthma in mid-adolescence. A study of her background revealed a home life full of tension and instability with an alcoholic father and a working mother who had little time for her; departure from her home alone, at the age of sixteen, to become

self-supporting in a strange city; and feelings of hostility coupled with dependence towards the foreign-mannered mother-in-law with whom she lives. This patient knew no real love from her family and was separated from her husband, towards whom she looked for security, soon after their marriage. Economic stress and the burden of a child before she was ready for it were additional factors.

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CHAPTER IV

SUMMARY AND CONCLUSIONS

Group A. Asthma: Intrinsic Type

A summary of the observations upon patients in Group A, Asthma Intrinsic Type, indicates the presence of certain common factors in their backgrounds:

As personalities these patients tended to be dependent, high strung, anxious, preoccupied with self, irritable, lacking in self-confidence, and permeated with feelings of inferiority. One was a nail biter and three were markedly hostile towards persons on whom they were dependent. These findings are in accord with the results of psychiatric investigations reported in Chapter II. All were very apprehensive during attacks, and five were genuinely frightened. One of these became excited during attacks, while three became discouraged or depressed, and one was afraid of dying. A bid for the sympathy and attention of the hospital staff and for that of members of the family was made by six of the group of patients, eight of whom had been hospitalized at least once.

Disturbance of the dependent relationship with one or both parents was apparent in all cases in the group, several cases manifesting more than one major symptom of this condition. One patient lost both parents through death while she was still a child, one male patient lost his mother, and one female her father, again through death. Two patients had alcoholic fathers and one an alcoholic mother. Geographical separation because of migration to America from Europe accounted for one disturbance of dependency

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while remarriage of a mother accounted for another.

Undemonstrative, overly strict, busy parents were present in four cases. In one, the patient was deprived of attention from the mother because whe was physically ill, in another because she resented his affectionate relationship with the father. One father was completely preoccupied with himself because of his own neurosis and consequently had no energy to devote to the patient, while another was openly hostile and unconcerned.

Four of the patients in Group A were married and in each marriage discord was present. All happened to be women. Two of the husbands were alcoholic, and two of the husbands were of a different religion. One of these wives feared that her husband would leave her if he discovered about her illegitimate child, one left her husband because he made another girl pregnant, and a third tried in vain to remake her husband in the pattern of her father.

Of the five single patients, three had expressed the desire to marry but were not very aggressive in carrying it to fulfillment. One broke his engagement when his fiancee told him to "shut up", while another stood by passively while the boy in whom she was interested married somebody else. As children, several of these patients showed marked rivalry with siblings, coupled with a desire to gain admiration from them. Two of the patients had stronger, more successful older siblings of whom they were very envious. Two of them were very dependent on older siblings and felt deserted by them when they were separated.

Only four patients in Group A had any children of their own. All four, however, showed annoyance at the presence of these children, and two of the children were illegitimate. One patient used her asthma as an excuse for

not caring physically for her child.

Family quarrels were found in five of Group A, the major reasons being economic and cultural. Alcoholism on the part of a spouse or parent, and religious differences were present in four cases. Economic stress was found to be due to the father's inadequacy in running his own business, and again, alcoholism.

Job dissatisfaction, present in all four of those who were working, was related to status of the particular job rather than to any specific difficulty connected with the work itself. One patient felt that the girls in her office were not good enough for her, another resented having to work in his father's candy store as clerk while his education had prepared him for something in the business world, and still a third felt that her job was not good enough since it did not compare in importance with that of her sister.

Religious and cultural problems in six of the group revolved around such considerations as adaptation to a new country, second generation conflict with European born parents, and marriage to a spouse of a different faith. One woman's religious life was so hectic that she had been raised under one church, married into another, and was now attending a third.

As a group these patients tended to have few if any friends. One not only had no friends herself but also tried to keep her husband from having any either.

Group B. Asthma: Intrinsic-Extrinsic Type

Observations and Comparisons with Group A

Common factors are also present in the backgrounds of patients in

Group B, Asthma Intrinsic-Extrinsic Type. As personalities they were generally similar to those in Group A except perhaps for a tendency towards restraint rather than expression of feelings. When hospitalized they seemed even more fearful than Group A, panic and terror at the thought of death being evident in several cases.

Disturbance of the dependent relation was also present in all cases as in Group A, but differed in that psychological attitudes on the part of parents, rather than death or separation, seemed to be the major factor. Parents were overprotective, over-solicitous, domineering and aggressive, often involved in their own neurotic difficulties to a point where the child was neglected. Only in one case was the father alcoholic, and only in one case had death of a parent (in this particular instance by suicide) disturbed the relationship.

As only two patients in this group were married it is difficult to judge the significance of the absence or presence of marital discord. It is of interest to note, however, that while both marriages were basically happy in that the patients expressed and felt love for the spouse and vice versa, in one case temporary separation was brought about by the induction of the husband into the armed service, and in the other by frequent psychotic episodes of the husband necessitating his hospitalization.

Sibling rivalry was, as in Group A, present in several cases and coupled with it was the desire for admiration. In one case when the sibling acted as a mother surrogate open hostility was apparent. Both women who were married resented their children and felt tied down because of them.

Family quarrels, present in only one case, were due to the conflicting personalities involved rather than to any external factors as economic

stress, alcoholism, or religious differences as in Group A. In another the patient quarreled with her mother-in-law due to cultural differences, but was perfectly happy with her husband.

Economic stress was present in five of the cases in Group B but, as in Group A, negative psychological attitudes towards work were more significant than any physical incapacity for work on the part of a parent or spouse. In one case financial difficulty was spasmodic, coinciding with periods of psychosis in the husband. The only two of the group who did work did not like the idea of working, constantly shifted jobs, and used their symptoms to keep from working. The question of status was not apparent as it had been in Group A.

Two patients did poorly at school, one because her guardians objected to the courses she wished to take and made her study ones she disliked, and another because her symptoms interfered with regular attendance.

Religious and cultural differences involved three of the group. In one case it was a problem of immigrant parents who had difficulty in assimilating, and in the other two, of relatives trying to impose their standards on the patients. Marriage to a man of different faith was also present in one of the above cases - a situation encountered in Group A. None of the patients in this group was successful in making many friends, a situation also encountered in Group A.

Comparison between Groups A and B of Social Events Preceding Onset and Exaccerbation of Disease

In analyzing social events preceding the onset of first symptoms it is interesting to note that patients in Group A tended to develop the disease after undergoing specific traumatic situations while in Group B it was more

difficult to make any correlation of onset with specific situations. Asthma in Group A developed for the first time in one patient after he received a letter from his mother criticizing him severely and saying that she was disappointed in him; another developed asthma after her father told her to leave home; still another after the reappearance of an illegitimate daughter who had been absent for many years and whose presence threatened to ruin the security of her home. Other events which preceded onset of symptoms were the birth of twin sons; the repeal of prohibition with the consequent beginning of heavy drinking on the part of the patient's husband; heavy drinking on the part of both parents; and the birth of siblings. One patient developed asthma in her senior year of high school at which time she wished to enter a convent to become a nun but was prevented from doing so by her father. Thus in eight out of nine patients in Group A, it was possible to make a definite temporal correlation of social data with first medical symptoms.

In Group B patients it was possible to make only two definite correlations, both of which, however, were similar to those of Group A. One of the patients developed her first symptoms after her husband had been committed to a mental hospital and she was left alone with six small children to care for; and the other, after she had left home at the age of sixteen to live by herself and earn her own living.

Exaccerbation, or increase, of symptoms seemed to occur after certain definite events in the patients of Group A. Five of these patients experienced attacks after being visited, while they were ill, by various members of their families. It was found by the medical staff that they got along

better if they were placed in a single room off the ward and were prohibited from having any visitors whatever. Four of the patients experienced new attacks on being told that they were well enough to be discharged from the neutral, protective environment at the hospital. Another patient began to have a series of attacks when told that she was well enough to work. Two patients became ill as plans for their going west to a drier climate were being made; both expressed the fear of going alone. In two instances attacks occurred after family quarrels. Exaccerbations by individual patients were experienced after such situations as the marriage of a motherly sister, the unexpected marriage of a boy friend to another girl, injury to a much loved brother, failure of attempted reconciliation with a husband, hospitalization and illness of a mother (two cases), and threat of disbanding a home to board out patient.

One patient experienced exaccerbations while working in his father's store, a task which he felt was beneath him, and another while working in an office where she felt the girls were not good enough for her - both situations involving the question of status. An exaccerbation occurred after one patient was kept from school by his father, and after another patient returned to live at home on the urging of her father, toward whom she had mixed feelings. One patient had exaccerbation during her husband's drinking episodes when he either ignored her or made unwanted sexual advances towards her.

In Group B only one patient had an attack on being told he was about to be discharged. Exaccerbations occurred in another during periods when her husband experienced episodes of psychosis and was institutionalized. These two instances are similar to those which were found in Group A. There

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In Group B only one patient had an attack on being told he was about to be discharged. Exacerbations occurred in another during periods when her husband experienced episodes of psychosis and was institutionalized. These two instances are similar to those which were found in Group A. There

were no definite correlations possible for the remaining patients in Group B.

Periods of remission or freedom from symptoms were observed in eight of the nine patients of Group A in instances when they were away from their emotionally charged homes. In the remaining two patients, remissions occurred unexpectedly in the hospital upon administration of exactly the same type and amount of treatment which had previously been unsuccessfully administered at home. One patient experienced a period of remission after learning that the brother whom she thought was severely injured would be all right.

Group B showed similar results in that half of the patients were better when they did not live at home. One had remissions at the home of an aunt; another, at the home of a married sister; still a third at a nursing home, which, like her own home, was surrounded by ragweed to which she was supposedly allergic. One patient's periods of remission coincided with improvement in the mental symptoms of her husband.

Restatement of Purpose

As stated in the Introduction, this paper involved the study of fifteen patients with bronchial asthma who were known to and treated at the medical, psychiatric and social service departments at the Peter Bent Brigham Hospital in the years 1939-1945. Particular emphasis was placed on the study of inter-familial relationships. The main purpose was to determine the presence or absence of:

1. Similar specific events or situations in the backgrounds of these patients.
2. Similar specific events or situations which coincided with the

onset of the disease.

3. Similar specific events or situations which coincided with subsequent periods of exaccerbation and remission.

The fifteen cases were divided into groups according to etiology. Group A was classified as intrinsic, or as having asthma caused by something within the person himself, and Group B was classified intrinsic-extrinsic, since external allergic factors as well as personal factors were present. After surveying the pertinent literature in the fields of medicine and psychiatry, the author made an analysis of the individual cases with life charts for six of the cases. This was followed by a comparison of observations on each patient in regard to events in the background at times of onset, exaccerbation and remission of attacks.

From these observations certain common features were found. These features, which constitute the conclusions of this paper, apply solely to the cases studied, and are not to be considered generalizations for all patients with bronchial asthma because of the limited number of cases on which they are based.

The conclusions as related to the three main points specified in the purpose may be stated briefly as follows:

(1) Events in the backgrounds of the patients:

Patients with intrinsic asthma showed disturbances of a dependent relationship with either or both parents in connection with events as death, separation, illness, alcoholism or remarriage of the parent. Psychological factors of rejection and of neurosis on the part of the parents, while often present in intrinsic cases, appeared more frequently in intrinsic-extrinsic

cases where external factors seemed to be of lesser importance.

Intrinsic cases showed greater amount of marital discord and family quarrels than did intrinsic-extrinsic cases. Both groups were annoyed by the presence of children, whom they tended to ignore. Sibling rivalry coupled with a desire for approval from the stronger, more successful sibling was present in both groups. Also noted in both groups was absence of friends, religious and cultural differences, and economic stress. Job dissatisfaction was related to the question of status in the intrinsic group, while in the intrinsic-extrinsic group it was present but did not seem related to anything in particular.

(2) Specific events related to onset of symptoms:

The patients with intrinsic asthma showed a definite tendency to develop their first symptoms in relation to specific events which disturbed the security of a dependent relationship with a parent or spouse with whom they felt insecure in the first place. Patients with intrinsic-extrinsic asthma showed no characteristic specific events which were related to the onset of symptoms.

(3) Events related to exaccerbations and remission of symptoms:

Patients with intrinsic asthma tended to have exaccerbations when they were upset by the presence of a person whose love they desired but with whom they felt insecure, or when they were in an emotionally charged atmosphere that offered no assurance or protection or of desired status. Intrinsic-extrinsic patients showed a relationship of exaccerbations to a similar type of situation but this was not demonstrated so often.

Patients with both intrinsic and intrinsic-extrinsic asthma experienced the largest number of remissions when they were away from home and the

disturbing emotional factors therein.

Approved,

Richard K. Conant

Dean

Approved,

Dean

APPENDIX

APPENDIX

SCHEDULE

I. The Individual

Age, sex, marital status, intelligence, occupation, place of birth, nationality, religion.

II. Medical

History of Asthma

Respiratory diseases

Other major diseases

Allergic reactions (hives, eczema, etc.)

Sensitivities

History of allergies and respiratory infections in other members of the family.

III. Psychiatric Opinion

IV. Social and Emotional

1. Description of personality.
2. Order of birth among siblings and total number of siblings in the family.
3. Brief school and work history with description of economic status.
4. Relationships, past and present, within the family:
   a. Father - personality, relation to patient, relationship to wife and children.
   b. Mother - personality, relationship to patient, relationship to husband and children.
   c. Siblings - relationship to patient.

5. Relationships with opposite sex:

   a. Marriage - personality of spouse and relationship to patient.

   b. Marital adjustment.

   c. Attitude towards children.

6. Relationships with other people.

7. Reaction to illness.

8. Reaction to hospitalization.

9. Emotional and social situations during periods of relative freedom from attacks.

10. Emotional situations preceding attacks.

BIBLIOGRAPHY

Books

Alexander, Franz, The Medical Value of Psychoanalysis. New York: W.W. Norton and Co., 1942.

Bray, George W., Recent Advances in Allergy. Third edition; Philadelphia, Pa.: P. Blakiston's Sons and Co., Inc., 1937.

Cobb, Stanley, Borderlands of Psychiatry. Cambridge, Mass.: Harvard University Press, 1943.

Coca, Arthur, and others, Asthma and Hay Fever in Theory and Practice. Springfield, Mass.: Charles C. Thomas Co., 1931.

Dunbar, H. Flanders, Emotions and Bodily Changes. New York: Columbia University Press, 1938.

_____, Psychosomatic Diagnosis. New York: Harper and Bros., 1943.

Horney, Karen, The Neurotic Personality of Our Time. New York: W.W. Norton and Co., 1937.

Levine, Maurice, Psychotherapy in Medical Practice. New York: The MacMillan Company, 1942.

Menninger, Karl A., Man Against Himself. New York: Harcourt, Brace and Co., 1938.

Meyer, Adolf, and others, Practical Clinical Psychiatry for Students and Practitioners. Philadelphia, Pa.: W.B. Blakiston's Sons and Co., Inc., 1930.

Rackemann, Francis, Clinical Allergy. New York: MacMillan Company, 1931.

Robinson, G. Canby, The Patient as a Person. New York: Commonwealth Fund, 1939.

Solomon, Harry C., and S. Yakovlev, editors, Manual of Military Neuropsychiatry. Philadelphia, Pa.: W.B. Saunders Co., 1944.

Thornton, Janet C., The Social Component in Medical Care. New York: Columbia University Press, 1937.

Vaughan, Warren T., Primer of Allergy. St. Louis, Mo.: C.V. Mosby Co.,1939.

Weiss, Edward, and Spurgeon English, Psychosomatic Medicine. Philadelphia, Pa.: W.B. Saunders Co., 1943.

Books

Committee Reports

French, Thomas, and Franz Alexander, "Psychogenic Factors in Bronchial Asthma," Psychosomatic Medicine Monographs, Part I, Vol. I and Parts I and II, Vol. II. Washington, D.C.: National Research Council, 1941.

Deutsch, Felix, Emotional Factors in Asthma and Other Allergic Conditions. A mimeographed paper, the American Association of Medical Social Workers, 1941.

Periodicals

Bartlett, Harriett, "Emotional Elements in Illness," The Family, 21:39-47, April, 1940.

Cobb, Stanley, and MacDermot, "A Psychiatric Study of Bronchial Asthma," Psychosomatic Medicine, 1:203-245, April, 1939.

Cockerill, Eleanor, "Adventures in Understanding," The Family, 20:155-160, July, 1939.

Dunbar, H. Flanders, "Psychoanalytic Notes Relating to Syndromes of Hay Fever and Asthma," Psychoanalytic Quarterly, 7:25, 1938.

Ewalt, Jack R., "Psychosomatic Problems," Journal of the American Medical Association, 126:150-153, September 16, 1944.

Fitzsimmons, Margaret, "Treatment of Problems of Dependency Related to Permanent Physical Handicap," The Family, 23:329-336, January, 1943.

Gordon, Eckka, "Treatment of Problems of Dependency Related to Illness," The Family, 23:210-218, October, 1942.

Halliday, J.L., "Approach to Asthma," British Journal of Medical Psychology, 17:53, 1937.

MacKenzie, Joseph N., "The Production of Rose Asthma by an Artificial Rose," American Journal of Medical Science, 1:45, 1886.

Rogerson, Charles H., and others, "A Psychological Approach to the Problem of Asthma," Guy's Hospital Review, (London, England) 85:289, 1935.

Saul, Leon, "Some Observations on the Relation of Emotion and Allergy," Psychosomatic Medicine, 3:66-72, January, 1941.

Silbert, Louise, "How the Clients Current Adjustment Affects Treatment Possibilities," The Family, 20:331-340, February, 1940.

Committee Reports

Periodicals

Stokes, John H., and Beerman, "A Psychosomatic Correlation in Allergic Conditions," Psychosomatic Medicine, 2:438-458, October, 1940.